Benefit Comparison Chart
For Members of the State Police Enlisted Unit

Effective October 7, 2007

Disclaimer: *This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or co-pay amounts required by the State Health Plan PPO. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.*

Preventative Services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
	$1,500 maximum per person per calendar year		
Health maintenance exam	Covered 100% one per calendar year	Not Covered	Covered 100% after $10 office visit co-payment
Annual gynecological exam	Covered 100% one per calendar year		
Pap smear screening – Laboratory services only*	Covered 100% one per calendar year		
Well-baby and child care	Covered 100% • 6 visits per year through age 1 • 2 visits per year, age 2 - 3 • 1 visit per year, age 4 - 15		
Immunizations and annual flu shot (age 17 and older)	Covered 100%		
Hepatitis C screening covered for those at risk	Covered 100%		
Fecal occult blood screening*	Covered 100% one per calendar year		
Flexible sigmoidoscopy*	Covered 100% one every 5 years		
Prostate specific antigen screening*	Covered 100% one per calendar year		

* American Cancer Society guidelines apply

Preventative Services Not Subject to Maximum Limit

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Childhood immunizations	Covered 100% for children through age 16	Covered 90% after deductible	Covered 100% after $10 office visit co-pay
Colonoscopy exam*	Covered 100%	Covered 90% after deductible	Check with your HMO
	Beginning at age 50. One every 10 years.		
Mammography screening*	Covered 100%	Covered 90% after deductible	Covered 100%
	One per calendar year.		

* American Cancer Society guidelines apply

Physician Office Services

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Office visits, consultations & urgent care visits	Covered after $10 co-pay	Covered 90% after deductible	Covered after $10 co-pay
Outpatient and home visits	Covered 100% after deductible		

Emergency Medical Care

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Hospital emergency room – approved diagnosis, prudent person rule	Covered 100% for medical emergency or accidental injury		$50 co-pay if not admitted
Ambulance services – medically necessary	Covered 100% after deductible		Covered 100%

Diagnostic Services

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Laboratory and pathology tests	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Diagnostic tests and x-rays			
Radiation therapy			

Maternity Services

(State Health Plan PPO includes care by a certified nurse midwife)	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Pre-natal and post-natal care	Covered 100% after deductible	Covered 90% after deductible	Office visit: $10 co-pay
Delivery and nursery care			Covered 100%

Hospital Care

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Semi-private room, inpatient physician care, general nursing care, hospital services, blood storage and supplies	Covered 100% after deductible, unlimited days	Covered 90% after deductible, unlimited days	Covered 100% unlimited days
Inpatient consultations	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Chemotherapy			

Alternatives to Hospital Care

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Skilled nursing care	Covered 100% after deductible up to 730 days per confinement		Covered 100%
Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the state		
Home health care	Covered 100% after deductible, unlimited visits		

Surgical Services

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Surgery – includes related surgical services	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Voluntary sterilization			

Human Organ Transplants

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Liver, heart, lung, pancreas and other specified organ transplants – covered in designated facilities only. Preauthorization is required.	Covered 100% in designated facilities only Up to $1 million maximum per transplant type		Covered 100% in designated facilities
Bone marrow – specific criteria apply	Covered 100% in designated facilities only		
Kidney, cornea and skin	Covered 100% after deductible	Covered 90% after deductible	Covered 100% subject to medical criteria

Other Services

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Allergy testing and therapy	Covered 100% after deductible	Covered 90% after deductible	Office visits: $10 co-pay; Injections: 100% covered
Acupuncture	Covered 90% after deductible if performed by or under the supervision of a M.D. or D.O. - 20 visit limit.		Check with HMO
Rabies treatment after initial emergency room visit	Covered 100% after deductible	Covered 90% after deductible	Office visit: $10 co-pay; Injections: Covered 100%
Hearing care program	$10 office visits; more frequent than 36 months if standards met		Check with HMO

Other Services continued…

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Chiropractic spinal manipulation	Covered 90% after deductible, up to 24 visits per calendar year		Check with HMO
Durable medical equipment (Covered by DME Vendor)	Covered 100%	Covered 80% plus the difference allowed amount and charge	Covered 100%
Prosthetic and orthotic appliances (Covered by DME Vendor)			
Private duty nursing	Covered 90% after deductible		Covered 100%
Wig, wig stand, adhesives (Covered by DME Vendor)	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of $300. Additional wigs covered for children due to growth.		Check with HMO

Outpatient Physical, Speech & Occupational Therapy

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Outpatient physical, speech & occupational therapy – facility and clinic services	Covered 100% after deductible Combined maximum of 90 visits per calendar year		Covered 100%
Outpatient physical therapy – physician's office	Covered 100% after deductible	Covered 90% after deductible	Office visit: $10 co-pay

Mental Health/Substance Abuse Services

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Inpatient substance abuse	Covered 100% - 28 days with a 60-day renewal and only 2 admissions per calendar year. No dollar maximum.		Check with HMO
Inpatient psychiatric	Covered 100% No dollar maximum.		
Outpatient substance abuse	Covered 90% for services rendered by a participating BCBS provider. Covered at 90% of BCBS's approved amount for services rendered by a non-participating BCBS provider. Subject to a $3,500 maximum per member per calendar year.		
Outpatient (office) psychiatric	Covered 90% for services rendered by a participating BCBS provider. Covered at 90% of BCBS's approved amount for services rendered by a non-participating BCBS provider.		
Residential care facility	Covered 100% for the standard length of treatment program		
Acute care hospital (using acute care beds)	Covered 67% of semi-private room and board charges and 100% of covered miscellaneous fees for the standard length of treatment program.		
Detoxification	Covered 100% for semi-private room and board and miscellaneous fees.		

Deductible, Co-Pays & Out-of-Pocket Dollar Maximums

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Deductible	$200 per member $400 per family	$500 per member $1,000 per family	None
Co-pays • Fixed dollar co-pays (does not apply toward deductible)	$10 for office visits, office consultations, urgent care visits	Not applicable	$10 office visits $50 emergency room visits, if not admitted
Co-pays • Percent co-pays	10% for chiropractic manipulation, chiropractic office visits, private duty nursing and acupuncture	10% for most services	None
Annual dollar maximums • Fixed dollar co-pays (does not apply toward out-of-pocket maximum)	Not applicable	None	None
Annual dollar maximums • Percent co-pays (private duty nursing co-pays do not apply toward out-of-pocket maximum)	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family	
Annual dollar maximum	$5 million lifetime per member for all covered services as noted above for individual services		

Mental Health Co-Payment

	State Health Plan PPO		HMO Benefits
	In-network	**Out-of-network**	
Deductible	Not applicable	Not applicable	Check with HMO
Percent co-pay	10% for outpatient psychiatric and outpatient substance abuse	10% for outpatient psychiatric and outpatient substance abuse. Non-participating providers are reimbursed according to BCBS's allowed amount minus the 10%.	

Prescription Drug Co-Payment

	State Health Plan PPO	HMO Benefits
Prescription drugs	Covered by Express Scripts, Inc. Generic $ 7.00 Brand Name Preferred $ 15.00 Brand Name Non-Preferred $ 30.00 All maintenance drugs filled at a participating pharmacy may only be approved for up to a 34-day supply. Members will still be able to pay a 1-month co-pay and receive up to a 90-day supply by mail order.	Generic $ 5.00 Brand Name $10.00